

Attachment A
Proposed Changes to Standard 2016 Community-Rated HMO Health Benefits Contract

NOTE: New and revised language is underlined and language to be deleted is ~~struck-out~~.

Self Plus One

1. Section 2.3 Payment of Benefits and Provision of Services and Supplies (JAN 20152016). We revised this Section to account for the Self Plus One enrollment type.

* * *

(f) When claim filing is required, Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If Benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such Benefits directly to a hospital or other provider of services or pay such Benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's Self Plus One or Self and Family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the child, then the Carrier may issue an identification card for the child(ren) to that person and, when claim filing is required, may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's Self Plus One or Self and Family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and when claim filing is required, the Carrier may reimburse that person for any covered medical service or supply.

(4) Compliance with the HIPAA Privacy Rule. The Carrier may pay Benefits to a covered person other than the Enrollee when in the exercise of its discretion the Carrier decides that such action is necessary to comply with the HIPAA Privacy Rule, 45 C.F.R. §164.500 et seq.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

2. Appendix B Subscription Rates, Charges, Allowances and Limitations. We revised Appendix B to include the Self Plus One enrollment type and to incorporate the Performance Assessment-based Performance Adjustment consistent with Appendix F.

(a) Biweekly net-to-carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, [subject to a Performance Assessment-based Performance Adjustment consistent with Appendix F](#) are as follows:

Self Only	\$ _____
Self Plus One	\$ _____
Self and Family	\$ _____

3. [Appendix C FEHB Supplemental Literature Guidelines](#). We revised Paragraphs (b) and (d) to include the Self Plus One enrollment type, to reflect the fact that we will not be producing a Guide to Federal Benefits this year, and to indicate that Carriers will need an SF 2809 from the personnel office to change the family member on a Self Plus One enrollment type. We amended Paragraph (f) in order to clarify the language and remove unnecessary text.

b) RATE PRESENTATIONS

Under the FEHBP there are only ~~two~~ [three](#) categories of enrollment, Self Only, [Self Plus One](#), and Self and Family. For most enrollments, the premium for each enrollee's enrollment is shared between the enrollee and the Government or Tribal Employer. The Government or Tribal Employer contribution is based on the formula provided in the FEHB law. Deductions for most enrollees' share, along with the Government's contribution or Tribal Employer's contribution, are made in accordance with the schedule on which the employee, Tribal Employee, or annuitant's (retiree) salary or annuitant check is issued by the Enrollee's agency, Tribal Employer, or retiree's retirement system. Most employees are paid biweekly. Annuitants are issued monthly checks.

Employees, Tribal Employees, and annuitants do not have separate categories of enrollment. They pay the same rates, whether on a biweekly, semimonthly, or monthly basis, and receive the same benefits when they are in the same FEHB Plan, except that active Postal employees pay a lesser share, as their cost sharing formula with the Postal Service calls for a greater Government contribution.

The Enrollee's share for each FEHB Plan for each type of enrollment (Self Only, [Self Plus One](#), and Self and Family) [can be found on the FEHB Program website](#). ~~This Guide is prepared each Open Season and is distributed directly to agencies by OPM; they in turn distribute the Guide to employees. The Guide will be made available to Tribal Employers to distribute to Tribal Employees.~~ Biweekly and monthly rates are also shown on an insert you prepare for your brochure. ~~Separate guides are prepared for special groups of Enrollees, including those for which the agency or Tribal Employer makes no premium contribution, such as former spouses and employees and family members with temporarily continued coverage.~~

In making your rate presentations:

1. With the exception of the Summary of Benefits and Coverage referenced at section 1.13(e), list your FEHB rates in each piece of supplemental material which lists benefits. Do not list the rates of any competitor Plan.
2. Immediately above the rates include the following statement:

"These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to [the FEHB Program website](#) ~~your special Guide to Federal Benefits~~ or contact the agency or Tribal Employer which maintains your health benefits enrollment."

3. If you wish to list Postal rates in addition to non-Postal rates, Postal and non-Postal rates should be clearly identified and listed separately. (Please note there are no monthly Postal rates; upon retirement, Postal employees receive the non-postal contribution.)

* * *

d) ENROLLMENT INSTRUCTIONS

Enrollment under the FEHBP is governed solely by the Federal Employees Health Benefits law and applicable regulations. The various Federal agencies and Tribal Employers have responsibility for administering the law and regulations during the annual open enrollment period (Open Season) and at all other times during the year. Agency and Tribal Employer personnel offices perform the basic health benefits functions, such as instructing employees about the conduct of the Open Season and other health benefits matters, answering employee questions, and processing elections and changes of enrollment, including determinations of eligibility and assignment of effective dates of coverage. Agency and Tribal Employer payroll offices make the necessary salary deductions.

The Federal instrument for electing to enroll in a Plan or changing an existing enrollment in a Plan from Self Only, [Self Plus One](#), ~~or to~~ Self and Family [to another category of enrollment \(or the reverse\)](#) is the Standard Form (SF) 2809, or alternative electronic or telephonic method approved by OPM. Carriers must be able to accept electronic file transfers. The effective date for Open Season enrollments is the first day of the first pay period which begins on or after January 1 for employees and Tribal Employees; the effective date generally is January 1 for annuitants. The specific effective date for an individual will be assigned by the individual's personnel office.

Covered family members are as defined in the FEHB regulations. Basically, family members are immediate family members, including spouse and children under age 26. When Self and Family coverage is established for an individual, all family members as defined under the regulations are automatically covered as of the effective date assigned by the personnel office, whether or not they are listed on the SF 2809, on other documents, or communicated by electronic or telephonic transmittal. Family members (e.g., newborns) who are added under an existing Self and Family enrollment are automatically covered from the date the individual becomes a family member, e.g., from birth. Personnel offices do not issue any notification when a new dependent is added under an existing Self and Family enrollment and the Enrollee does not submit a new SF 2809 or other election instrument. [For a Self Plus One enrollment, the Carrier is required to receive an SF 2809 from the personnel office with enrollment information about the designated covered family member. If an employee wishes to change the designated covered family member to another eligible family member, the Carrier is required to receive a new SF 2809 from the personnel office with enrollment information about the new designated covered family member.](#)

The agencies and Tribal Employers are the primary contact point for employees and Tribal Employees on health benefits enrollment matters. OPM's Office of Retirement Programs performs this function for annuitants (retirees). As highlighted below, carriers may not impose their own enrollment requirements and procedures.

1. Do not give specific instructions on enrollment.
2. While the Carrier may ask Enrollees for information (see Section f) and may follow-up with Enrollees and, when necessary, the employing office, the Carrier will not require a member complete plan specific enrollment or application forms. (You may ask the Enrollee to complete "information" forms.) You may ask the Enrollee to keep you advised of family member changes and you may verify the change, but failure to complete a form does not render an eligible family member ineligible.
3. Personnel offices will not stock your Plan's forms. Do not indicate otherwise.
4. If supplemental literature is directed to potential members rather than just-enrolled members, do not include statements indicating otherwise.
5. Again, the Federal brochure, rather than any other plan document, is the member's complete statement of benefits. Do not indicate otherwise.

* * *

f) INFORMATION FORMS

You may distribute forms to obtain information from Enrollees about the Enrollee and any family members. For instance, to obtain the information regarding Medicare you will need for rate-setting purposes under the Federal Program, you may ask who is enrolled under Medicare Part A, Medicare Part B or Medicare Parts A and B. For another example, ~~Health Maintenance Organization Carriers~~ you may ask that a primary care doctor be selected. If you wish to distribute an information form, you may find such forms are more readily returned if they are postage-paid. If the Member must select a medical group or independent physician association, also provide space for the Member to make such a selection. Do not indicate enrollment in the Plan is contingent upon completing and returning the form. ~~The form should follow the requirements listed below:~~

~~————(1) If the Member must select a medical group or IPA, also provide space for the Member to make such a selection.~~

~~————(2) Do not indicate enrollment in the Plan is contingent upon completing and returning the form.~~

Subrogation

4. Section 2.5 Subrogation (JAN 19982016). We revised this Section to expressly include language that benefits and benefit payments are extended to members with the condition that Carriers have a subrogation right. All CR-HMO and ER-HMO carriers are entitled to full subrogation and reimbursement rights regardless of State law. These changes are reflected in 5 CFR 890.101(a) and 890.106(b) and (f).

(a) The Carrier must condition the extension of benefits and benefit payments to covered individuals on its rights to subrogation and reimbursement under 5 CFR 890.106.

~~(a)(b) The Carrier shall subrogate FEHB claims in the same manner in which it subrogates claims for non-FEHB members,~~ according to the following rules:

- (1) The Carrier shall subrogate FEHB claims if it is doing business in a State in which subrogation is permitted, and in which the Carrier subrogates for non-FEHB members;
- (2) The Carrier shall subrogate FEHB claims if it is doing business in a State in which

subrogation is prohibited, but in which the Carrier subrogates for at least one non-FEHB plan covered under the Employee Retirement Income Security Act of 1974 (ERISA);

(3) The Carrier ~~shall~~ may choose not to subrogate FEHB claims if it is doing business in a State that prohibits subrogation, and in which the Carrier does not subrogate for any non-FEHB plan under ERISA;

(4) For Carriers doing business in more than one State, the Carrier shall apply the rules in (1) through (3) of this subsection according to the rule applicable to the State in which the subrogation would take place.

(c) The Carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier. The Carrier has the right to file suit in Federal court in order to enforce its rights to subrogation and reimbursement.

~~(d)(b)The Carrier's subrogation procedures and policies shall be shown in the agreed upon brochure text or made available to the enrollees upon request.~~ The Carrier's subrogation and reimbursement policies for payments with respect to benefits shall be explained in the plan brochure.

(e) Subrogation recoveries may be reduced by any legal or subrogation vendor fees expended to obtain the recoveries and which are not otherwise payable under this contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or subrogation vendor fees.

FEHB Plan Assessment

5. Section 3.1 Payments—Community-Rated Contracts (~~JAN 2003~~ JAN 2016) (FEHBAR 1652.232-70). We updated this clause to conform to recent regulation changes.

(a) OPM will pay to the Carrier, in full settlement of its obligations under this contract, ~~(subject to adjustment for error or fraud),~~ the subscription charges received for the plan by the Employees Health Benefits Fund (hereinafter called the Fund) less the amounts set aside by OPM for: 1) the Contingency Reserve, 2) and for the administrative expenses of OPM, amounts assessed under FEHBAR 1609.7101-2, and amounts 3) for obligations due pursuant to paragraph (b) of this clause, and 4) the performance adjustment described at 1615.404-4; plus any payments made by OPM from the Contingency Reserve.

6. Appendix F FEHB Plan Performance Carrier Letters. We added two Carrier Letters 2015-10 and 2015-15 regarding FEHB plan performance as Appendix F (see Attachments).

FAR Clause Change

7. Section 5.14 Utilization of Small Business Concerns (~~MAY 2014~~) (JAN 2016) (FAR 52.219-8). We updated this Section to include the recent FAR changes.

(a) Definitions. As used in this contract --

“HUBZone small business concern” means a small business concern that appears on the

List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration.

“Service-disabled veteran-owned small business concern”

(1) Means a small business concern—

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a service-disabled veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16).

“Small business concern” means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.

“Small disadvantaged business concern”, consistent with 13 CFR 124.1002, means a small business concern under the size standard applicable to the acquisition, that--

(1) Is at least 51 percent unconditionally and directly owned (as defined at 13 CFR 124.105) by—

(i) One or more socially disadvantaged (as defined at 13 CFR 124.103) and economically disadvantaged (as defined at 13 CFR 124.104) individuals who are citizens of the United States; and

(ii) Each individual claiming economic disadvantage has a net worth not exceeding \$750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(2) The management and daily business operations of which are controlled (as defined at 13.CFR 124.106) by individuals, who meet the criteria in paragraphs (1)(i) and (ii) of this definition. ~~means a small business concern that represents, as part of its offer that--~~

~~(1)(i) It has received certification as a small disadvantaged business concern consistent with 13 CFR part 124, Subpart B;—~~

~~(ii) No material change in disadvantaged ownership and control has occurred since its certification;~~

~~(iii) Where the concern is owned by one or more individuals, the net worth of each individual upon whom the certification is based does not exceed \$750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and—~~

~~(iv) It is identified, on the date of its representation, as a certified small disadvantaged business in the Dynamic Small Business Search database maintained by the Small Business Administration, or~~

~~(2) It represents in writing that it qualifies as a small disadvantaged business (SDB) for any Federal subcontracting program, and believes in good faith that it is owned and controlled by one or more socially and economically disadvantaged individuals and meets the SDB eligibility criteria of 13 CFR 124.1002.~~

“Veteran-owned small business concern” means a small business concern—

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or

more veterans.

“Women-owned small business concern” means a small business concern—

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(b) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for major systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(c) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

~~(b)~~(d)(1) Contractors acting in good faith may rely on written representations by their subcontractors regarding their status as a small business concern, a veteran-owned small business concern, a service-disabled veteran-owned small business concern, a small disadvantaged business concern, or a women-owned small business concern.

(2) The Contractor shall confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing the System for Award Management database or by contacting the SBA. Options for contacting the SBA include—

(i) HUBZone small business database search application web page at http://dsbs.sba.gov/dsbs/search/dsp_searchhubzone.cfm; or <http://www.sba.gov/hubzone>;

(ii) In writing to the Director/HUB, U.S. Small Business Administration, 409 3rd Street, SW., Washington, DC 20416; or

(iii) The SBA HUBZone Help Desk at hubzone@sba.gov.

Minor and Technical Changes

8. Section 1.9 Plan Performance – Community-Rated HMO Contracts (JAN ~~2015~~2016). We revised this Section by changing the Initial Call Resolution standard from 60 percent to 80 percent. The FEHB standard was below the industry standard of 90% to 95% and to align it with industry, we will increase the standard to 80% this year and phase-in this standard over the next two contract years until we reach 90%. The FEHB average for this measure is 90%.

* * *

(iv) *Initial Call Resolution* – the percentage of issues resolved during the initial call.
REQUIRED STANDARD: On average, caller’s issues must be resolved during the initial call at least ~~60~~80 percent of the time.

9. Section 2.2 Benefits Provided (JAN ~~2015~~2016). We added Paragraph (i) to ensure that Carriers include non-physician providers when acting within the scope of their licenses under State law.

* * *

(i) In accordance with Section 2706(a) of the Public Health Service Act as added by the Affordable Care Act, the Carrier shall not discriminate, with respect to participation under the plan or coverage, against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.

10. Appendix D Rules for Coordination of Benefits. We revised Appendix D to the October 2013 version of the NAIC Coordination of Benefits Guidelines.

APPENDIX D
RULES FOR COORDINATION OF BENEFITS
Model Regulation Service--~~October 2013~~July 2005
National Association of Insurance Commissioners

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

* * *

B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

Drafting Note: The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts (often referred to as “med pay”), which is included in the definition of “plan” under Section 3K(3) of this model regulation, does not normally contain order of benefit determinatio provisions. As such, unless state law or regulation specifies otherwise, in accordance with paragraph (1), such coverage would be primary. Med pay coverage is not liability coverage and is not dependent upon fault.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital

and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

(1) Non-Dependent or Dependent

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(ii) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Drafting Note: The provisions of Subparagraph (b) address the situation where federal law requires Medicare to be secondary with respect to group health plans in certain situations despite state law order of benefit determination provisions to the contrary. One example of this type of situation arises when a person, who is a Medicare beneficiary, is also covered under his or her own group health plan as a retiree and under a group health plan as a dependent of an active employee. In this situation, each of the three plans is secondary to the other as the following illustrates: (1) Medicare is secondary to the group health plan covering the person as a dependent of an active employee as required pursuant to the Medicare secondary payer rules; (2) the group health plan covering the person as a dependent of an active employee is secondary to the group health plan covering the person as a retiree, as required under Subparagraph (a); and (3) the group health plan covering the claimant as retiree is secondary to Medicare because the plan is designed to supplement Medicare when Medicare is the primary plan. Subparagraph (b) resolves this problem by making the group health plan covering the person as a dependent of an active

employee the primary plan. The dependent coverage pays before the non-dependent coverage even though under state law order of benefit determination provisions in the absence of Subparagraph (b), the non-dependent coverage (e.g. retiree coverage) would be expected to pay before the dependent coverage. Therefore, in cases that involve Medicare, generally, the dependent coverage pays first as the primary plan, Medicare pays second as the secondary plan, and the non-dependent coverage (e.g. retiree coverage) pays third.

The reason why Subparagraph (b) provides for this order of benefits making the plan covering the person as dependent of an active employee primary is because Medicare will not be primary in most situations to any coverage that a dependent has on the basis of active employment and, as such, Medicare will not provide any information as to what Medicare would have paid had it been primary. The plan covering the person as a retiree cannot determine its payment as a secondary plan unless it has information about what the primary plan paid. The plan covering the person as a dependent of an active employee could be subject to penalties under the Medicare secondary payer rules if it refuses to pay its benefits. The plan covering the person as a retiree is not subject to the same penalties because, in this particular situation, as described above, which does not involve a person eligible for Medicare based on end-stage renal disease (ESRD), the plan can never be primary to Medicare. As such, out of the three plans providing coverage to the person, the plan covering the person as a dependent of an active employee can determine its benefits most easily.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
- (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity

has actual knowledge of the court decree provision;

- (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;
- (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or
- (iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (I) The plan covering the custodial parent;
 - (II) The plan covering the custodial parent's spouse;
 - (III) The plan covering the non-custodial parent; and then
 - (IV) The plan covering the non-custodial parent's spouse.

- (c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

Drafting Note: Subparagraph (c) addresses the situation where individuals other than the parents of a child are responsible for the child's health care expenses or provide health care coverage for the child under each of their plans. In this situation, for the purpose of determining the order of benefits under this paragraph, Subparagraph (c) requires that these individuals be treated in the same manner as parents of the child.

- (d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.
- (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the

order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parents(s) and the dependent's spouse.

Drafting Note: Subparagraph (d) is intended to address the situation created by the enactment of Section 2714 of the Public Health Service Act, as that section was added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) (ACA), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Section 2714 of the PHSA extended coverage for dependents to age 26 regardless of any dependency factors, such as support, residency, student status or marital status.